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Public Health Committee, Insurance and Real Estate Committee and Human Services Committee
February 14, 2011
American Cancer Society Testimony

SB 921 - An Act *Establishing A State Health Insurance Exchange* & HB 6323 - *An Act Making Conforming Changes To The Insurance Statutes Pursuant To The Federal Patient Protection And Affordable Care Act, And Establishing A State Health Partnership Program.*

The American Cancer Society is in the business of saving lives, which means preventing cancer or finding it early, seeking new cures, and caring for those in treatment. Throughout the health care reform legislative process, we have used the "cancer lens" to focus our efforts on achieving specific goals within the legislation. Now, as we shift to implementing the law, we will continue to use the "cancer lens" to guide all of our recommendations.

The Patient Protection and Affordable Care Act ("PPACA") requires the creation of state-based health insurance exchanges for individuals and small businesses to purchase insurance by January 1, 2014. Exchanges are essentially organized insurance marketplaces, which, if they are designed and function well, could provide consumers with a "one-stop shop" to compare and purchase health insurance and enroll in public coverage programs, as well as use the power of a large risk pool to generate competition among health plans based on quality and cost.

While the federal government (primarily through the Department of Health and Human Services ("HHS")) will set minimum standards, the new law delegates primary responsibility for governance and operation of the exchanges to the states.

Through provisions in both SB 921 and HB 6326, Consumers and small business owners will be able to compare and purchase insurance plans in person, through the mail, phone or a web portal that contains comparative information about participating insurers, including eligibility, availability, covered benefits, premium rates, cost- sharing, provider networks, and critical financial information such as the amount plans spend to pay claims relative to administrative costs (also known as the "medical loss ratio").

Consumers will be able to use an electronic calculator to determine their actual cost of coverage, taking into account any premium assistance they receive. Both bills require the exchanges to maintain a toll- free consumer assistance hotline and make information available in a culturally and linguistically appropriate manner.
The comprehensiveness of coverage in each bill is standardized into four "tiers":

bronze, silver, gold and platinum, with bronze plans being the least generous and platinum being the most generous. All participating plans must offer at least a silver and gold level option.

There are deficiencies, however. To achieve a more rational, transparent market, competition based on value and not cherry-picking, and lower premiums overall, improvements to both bills should be made.

The governance of the exchanges is critical to their long-term viability. The PPACA leaves the state to decide the specifics of what sort of oversight body and staff leadership the exchanges must have. The law also says nothing about the size or composition of a governing board; such as whether patient advocates should have designated seats, or whether insurance company executives should be barred from participating (as they are in Massachusetts). ***As such, it is critical that the legislation minimize the potential for abuse by those with a financial interest looking for access and influence.***

HB 6323 reduces the potential for a conflict of interest by specifying that directors may not be employed by the insurance industry, health care providers or hospitals. SB 921, however, requires that at least one member of the board is specifically under the employment of the insurance industry and one member be a healthcare provider.

We have long advocated that consumers need to have a voice and while SB 921 provides for one position out of 13, given the significant industry representation among the other positions, this creates a potential for unchecked undue influence. Despite the importance of consumer presence, HB 6323 provides no requirement for consumer representation.

In a further effort to strengthen the exchange and minimize the potential for abuse, we would recommend that all members with ties to specific groups, including industry and consumers, be barred from serving as directors, but instead be appointed by the board to serve on advisory committees charged with specific tasks or issue areas relating to their expertise. At a minimum, the consumer representative should have a longer starting term. Changing the only consumer representative so early in the planning process will make it difficult for that member (especially a new one who replaces the termed out member mid process) to have a strong voice.

Additionally, Sec. 15(a)(7) of HB 6326 and Sec. 5 (b)(8) of SB 921 both allow for the solicitation, receipt or acceptance of aid, grants or contributions *from any source* to carry out the provisions of the Exchange. ***This language should be changed to minimize the potential for abuse by providing appropriate limitations and oversight. At a minimum, the Exchange should be subject to the same lobbying and gift restrictions as the General Assembly and the rest of state Government.*** SB 921 does not take needed steps to minimize the potential for adverse selection,

an essential key to the long-term viability of exchanges. In past state experiments, exchanges have tended to attract sicker and more costly enrollees. These sicker enrollees tend to drive premium prices higher, causing healthier individuals to seek coverage elsewhere, compounding the problem of increasing premium costs. In insurance terms, this is known as a "death spiral".

Because the PPACA allows an insurance market to exist outside of the new exchanges, there is a high risk that health plans and employers will take advantage of the rules to "dump" people with high health costs into the exchange. PPACA includes some provisions to try to mitigate this risk, but additional safeguards are necessary.

PPACA requires health plans to treat individuals in all of their plans (except for grandfathered plans) as part of a single risk pool, and must agree to charge the same premium rate for a plan they market both inside and outside the exchange. However, these provisions would not affect to health plans that operate exclusively outside the exchange, and plans are not required to offer the same products in and outside the exchange. That doesn't mean they cant, however.

We would recommend that insurers wanting to sell bronze or catastrophic plans outside the exchange should have to sell such products inside the exchange as well. Keeping the rules the same for plans inside and out of the exchanges is critical to discouraging them from using differences in the rules to game the system and divide the sick from the healthy.

At a minimum, the exchange or Insurance Commissioner should report on adverse selection occurrences on a regular basis to the general Assembly and should be required to make specific recommendations to combat it as is required in Sec. 15 (b) (7) of HB 6326.

The new health insurance exchanges are critical to the success of health care reform. In order for cancer patients and their families to experience real changes in their ability to access, choose, and purchase comprehensive health insurance that meets their needs, policymakers at the national and state level must tackle critical challenges related to the design, implementation and governance of these new exchanges. As always, we appreciate the opportunity to inform this process and are available to work with the members of these committees to ensure greater access to health care for all of Connecticut's citizens.

Thank you.

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